PRINTED: 08/01/2011 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPI	LETED
		155496	B. WIN			07/06/2	2011
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			MISHAWAKA RD		
VALLEY	VIEW HEALTH CA	RE CENTER			RT, IN46517		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	or a Recertification and	F ₀	000	This facility requests that the	is plan	1
	State Licensure			000	of correction be considered		
	State Licensuic	Survey.			credible allegations of		
	C D				compliance. Submission of		
	1	June 27-July 1 and July			response and Plan of Corre		
	5-6, 2011				is not a legal admission that		
					deficiency exists or that this statement of deficiency was		
	Facility number	: 000523			correctly cited and is also n		
	Provider numbe	r: 155496			be construed as an admission of		
	AIM number: 1	00266930			interest against the facility,		
					Administrator, or any emplo		
	Survey team:				agents, or other individuals		
	1	N TC			draft or may be discussed i		
	Honey Kuhn, R				response and Plan of Corre		
	Carol Miller, Ri	N			In addition, preparation and submission of the Plan of	i	
					Correction does not constitu	ute an	
	Census bed type	e:			admission or agreement of		
	SNF/NF: 106				kind by the facility of the tru		
	Total: 106				any facts alleged or the		
					corrections of conclusions		
	Census payor ty	ne.			forth in this allegation by the		
	Medicare: 12	P • • • • • • • • • • • • • • • • • • •			survey agency. According	ly, the	
	Medicaid: 74				facility has prepared and submitted this Plan of Corre	action	
					prior to the resolution of ap		
	Other: 20				this matter solely because		
	Total: 106				requirements under State a		
					Federal law that mandates		
	Sample: 22				submission of the Plan of		
					Correction as a condition to		
	These deficience	ies reflect state findings			participate in the Title 18 ar		
		nce with 410 IAC 16.2.			19 programs. The submiss		
	citcu iii accoitua	nec with 710 IAC 10.2.			Plan of Correction within the		
	1				i innename soono in no wav	/ UE UI	1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Quality review 7/11/11 by Suzanne

TITLE

the facility.

non-compliance or admission by

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Williams, RN

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X2)			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155496	B. WIN			07/06/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				MISHAWAKA RD		
\/\	VIEW HEALTH CAF	DE CENTED			RT, IN46517		
VALLET	VIEW HEALTH CAP	RECENTER		ELKHA	K1, IN40517		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)		DATE
F0333	•	nsure that residents are					
SS=D	free of any signific	ant medication errors.	1				
	Based on record	review and interview, the	F0	333	F333 Residents Free of		08/02/2011
	facility failed to	ensure the accurate			Significant Med Errors I. W	Vhat	
	dosage of Morph	ine Sulfate was			corrective actions will be		
		ordered for 1 of 22			accomplished for those		
		ed for medications in a			residents found to have bee	en	
					affected by the deficient practice: The affected resident.	ont	
	sample of 22. (R	tesident #109)			no longer resides at the	ent	
					facility. II. How have other		
	Finding includes	:			residents having the potent	ial	
					to be affected by the same		
	The closed record	d of Resident #109 was			deficient practice been		
	reviewed on 07/0	05/11 at 2:15 p.m.			identified and what correcti	ve	
		as admitted to the facility			actions will be taken for the	se	
		diagnoses including, but			residents: a. A whole-hous	е	
					audit was performed by		
		HF (congestive heart			contracted Pharmacy Service		
	, · ·	lure, and osteoarthritis.			from July 11, 2011 to July 18		
	The resident was	admitted to a hospital on			2011 to compare each resid		
	06/16/11 and retu	urned to the facility on			Medication Administration Re (MAR) with the medications in		
	06/21/11 at 1:30	p.m. with Hospice			medication carts for that	iii tiic	
	services arranged	I for end of life care and			resident. (Attachment A) b.		
	services.				Issues identified in the audit	were	
	561 (1665)				corrected and family, resider	nt, or	
	Daviary of a mby	sician's order indicated:			POA and physician was mad	le	
					aware. III. What measures	will	
	•	nine 10 mg (milligrams)/5			be put into place or what	_	
	,	30 cc (vial) 2.5 ml q			systemic changes will be m		
	(every) 2 hr (hou	r) PRN (as needed)			to ensure that the deficient		
	muscular skeleta	l pain."			practice does not recur: a. Licensed Nurses will comple		
					Medication to Medication	ic a	
	Review of a hand	l written MAR			Administration Record		
		ninistration Record),			Comparison each time they		
	dated 06/22/2011-06/30/2011, indicated:			receive new medication for a	ı		
		<i>'</i>			resident. This will be done be	efore	
	•	g/5 ml: 30 cc (vial) 2.5			the medication is loaded into	the	
	ml q 2* (hour) Pl	RN muscular skeletal			medication cart. Nurses will		

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155496	B. WIN			07/06/2	011
		ll	P. (12.)		ADDRESS, CITY, STATE, ZIP CODE	I	
NAME OF 1	PROVIDER OR SUPPLIEF	8		1	MISHAWAKA RD		
VALLEY	VIEW HEALTH CAI	RE CENTER		1	RT, IN46517		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	pain". (5 mg=2.	5 ml)			complete "MEDICATION CAI		
	In addition, the I	MAR indicated:			TO MAR AUDIT" (Attachmen	it B)	
	"Morphine 100 i	ng/5 ml 0.25 ml q 2*			log each time they intake medications and must sign to	,	
	PRN for muscul	ar skeletal pain" (5			show that the audit has been		
	mg=.25 ml)	1			completed and the medication		
					match the Medication		
	Review of "Posi	dent Progress Notes"			Administration Record. If the	ere is	
		dent i logiess notes			a discrepancy, they must		
	indicated:				immediately notify the Unit		
	,	entry for 1600 [4:00			Manager PRIOR to giving the medication or stocking it into		
	A 2/	ion variance noted. DNS			med cart. Clarification will be		
	,	g Services), MD			sought as needed and		
	(Medical Doctor	e), ED (Executive			medications returned to the		
	Director) notifie	d. Family @ (at) bedside.			pharmacy as needed. b.		
	N.O. (New Orde	er) to check O2 (oxygen)			Licensed nurses and QMAs		
	sat (saturation) &	& (and) resp (respirations)			inserviced by Staff Developm		
	` ′	es) X 2* then q hr X 4*.			Coordinator regarding proper Medication Administration	1	
	1 -	l) next dose. Call EMS			techniques. (Attachment C.)	.C.	
	,	: per minute) 12 or sat <			PharMerica has instituted a r		
	_ ` `	* '			process for any concentration	n	
	`	d pressure) 122/54, P			change of Morphine Liquid		
		espiration) 16, O2 sat on			Prescriptions (Attachment D)		
	2 L/MN (2 liters	/minute) = 91 %."			This process change took eff	tect	
					on July 6, 2011 and was communicated to all PharMe	rica	
	"06/24/11 1645	(4:45 p.m.) Spoke c			staff on the same day. The	iica	
	(with) family reg	garding N/O (new order)			process change is as follows	: For	
	to send to ER if	family wished. They			any change of concentration	in	
		d like her to stay @			Morphine Liquid Prescription	s:	
	I -	nt lying in bed c eyes			A copy of the new written		
	1 -	en et (and) unlabored @			prescription or the physician telephone order must be prin	uted	
	this time."	(a.i.a.) umasor ea (a.			The word "VOID" must be wr		
	diis tiiit.				boldly across the face of the		
					order or prescription and this		
	The documentation indicated Resident #109 continued to be monitored as				copy must be attached to the		
					newly dispensed medication.		
		pirations at a rate of 10			PharMerica staff must docum		
	recorded twice.	The family remained at			this change of concentration	with	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLE	TED
		155496	B. WIN			07/06/20	11
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	8			MISHAWAKA RD		
\/\	VIEW HEALTH CAI	DE CENTED		1	RT, IN46517		
				<u> </u>	101, 114-0517		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1	aghout the course of the			the nurse's name, date and t		
	resident's stay.	The resident continued to			IV. How will the corrective	I .	
	receive PRN pai	n medication as ordered.			actions be monitored to en- the deficient practice will n		
	The resident exp	oired on 06/26/11 at 1850			recur, i.e., what quality	·	
	(6:50 p.m.).				assurance program will be	nut	
	(0.00 p.iii.).				into place: a. Unit Manage	•	
	The DNS was in	terviewed on 07/06/11 at			will check MARs daily (Mond		
					through Friday) to ensure that	· .	
	1	ards to the "variance".			"MEDICATION CARD TO MA		
		ted Resident #109			AUDIT" (Attachment B) is be		
	1	ne Sulfate 100 mg/5 ml			completed as medications ar	e	
	dose of 2.5 ml,	or 50 mg, rather than the			stocked, and that any discrepancies have been rep	orted	
	transcribed .25 n	nl, or 5 mg, as ordered.			and clarified or corrected price		
	The DNS indica	ted the pharmacy would			medication administration or		
		the facility and mark the			stocking. This will continue for		
	1	fferent concentration as			period of three months, with		
		DNS indicated the			weekly checks thereafter. b		
	1 ^	administered by a QMA			Director of Nursing Services	or	
		• •			her designee will perform a	_N_	
	, ·	cation Aide) after the			weekly review of "MEDICATI CARD TO MAR AUDIT"		
		essed by LPN #3 as the			(Attachment B) logs for each	unit	
	facility protocol	requires. The DNS			to ensure they have been		
	indicated the QN	AA noted the discrepancy			completed and that discrepa	ncies	
	following the ad	ministration of the			have been followed up and		
	medication when	n recording on the MAR			clarification has been sought		
		notified LPN #3, who in			This will continue for a period	d of	
	1	appropriate staff. The			three months, with monthly checks thereafter. c. Directo	.r.of	
	1	copy of the vial sent by			Nursing Services or her desi		
	1 ^				will audit one resident's	grice	
	the pharmacy wl				medications per week to ens	ure	
	1 -	te oral solution. 100 mg			that the Medication Administ		
	per 5 ml (20 mg/	· ·			Record and the Medications	in	
	The label did not indicate the Morphine				the Medication Cart for that		
	was other than the	ne physician's order of			resident match. The	_	
	Morphine 10 mg	g/5 ml.			MEDICATION CARD TO MA		
					AUDIT (Attachment B) will be used for this audit. This will	-	
	Review of a Poli	icy and Procedure, titled,			continue for a period of three	,	
	1 110 110 11 01 01 01	and i roccadio, titioa,			continuo for a portoa of tilloc		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496		(X2) MULTIPLE A. BUILDING B. WING	OO	ľ	e survey pleted /2011	
	PROVIDER OR SUPPLIER		STRE 333	ET ADDRESS, CITY, STATE, ZIP O W MISHAWAKA RD HART, IN46517	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	provided by the I indicated: "Procedure: Prep Administration: 7. Prepare the m rights of mediation Right patient, Right medication Right time of administration and the requency Right route of administration and compare with label(s) c. Read the mediand compare with label(s)	aration to Medication edication using the five on administration: a name and strength, and ministration, ministration		months, with monthly thereafter. d. Result will be presented to Performance Improve Committee monthly of six months for revextension of review needed. Determinate of extension will be incidents of non-confluenting or continuer incorrect dosage / confluents of auditing or medication deliver from pharmacy as different results of auditing an monitoring. V. Compate: 8-2-11	olts of Audits the vement for a period view with period as ion for need based on inpliance with d issue with oncentration ired letermined by ind	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155496	B. WINC			07/06/2	011
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				MISHAWAKA RD		
\/\\ EV \	VIEW HEALTH CAF	DE CENTED			RT, IN46517		
					101, 11040317		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	rE .	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0425		rovide routine and and biologicals to its					
SS=D		n them under an agreement					
		.75(h) of this part. The					
		unlicensed personnel to					
		f State law permits, but only					
	under the general	supervision of a licensed					
	nurse.						
	A facility must prov	vide pharmacoutical					
		vide pharmaceutical g procedures that assure the					
	, ,	g, receiving, dispensing, and					
		Il drugs and biologicals) to					
	meet the needs of	0 ,					
		mploy or obtain the services					
	·	macist who provides					
	pharmacy services	aspects of the provision of					
		review and interview, the	F04	125	F 425 Pharmaceutical SVC	_	08/02/2011
		ensure the dosage of		.23	Accurate Procedures I. Wh	_	00/02/2011
	_	e was clearly labeled and			corrective actions will be		
	•	ordered for 1 of 22			accomplished for those		
		ed for medications in a			residents found to have been		
	sample of 22. (R				affected by the deficient practice: Affected Resident	no	
	sample of 22. (N	resident #109)			longer resides in the facility.		
	Finding includes				How have other residents		
	rmanig includes				having the potential to be		
	The closed masses	d of Dagidant #100as			affected by the same deficie		
		d of Resident #109 was			practice been identified and		
		05/11 at 2:15 p.m.			what corrective actions will		
		as admitted to the facility			taken for those residents: a whole-house audit was	л. A	
	on 11/29/10 with	diagnoses including, but			performed by contracted		
	not limited to, Cl	HF (congestive heart			Pharmacy Services from July	/ 11,	
	failure), renal failure, and osteoarthritis. The resident was admitted to a hospital on			2011 to July 18 , 2011 to	,		
				compare each resident's			
06/16/11 and returned to the facility on			Medication Administration Re				
		p.m. with Hospice			(MAR) with the medications i	n the	
	00/21/11 at 1.30	p.111. with 1105pice			medication carts for that		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XT6Y11

Facility ID:

000523 If continuation sheet

Page 6 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155496	B. WIN			07/06/2011
			D. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹				
\/\	VIEW HEALTH CAI	DE CENTED			MISHAWAKA RD	
VALLET	VIEW REALTH CAI	RECENTER		ELNHAI	RT, IN46517	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	DATE
	services arranged for end of life care and				resident. (Attachment A) b.	
	services.				Issues identified in the audit	
					corrected and family, reside	The state of the s
	Review of a phy	sician's order indicated:			POA and physician was mad	
					aware. III. What measures	WIII
	•	nine 10 mg (milligrams)/5			be put into place or what systemic changes will be n	nada
	` ′	30 cc (vial) 2.5 ml q			to ensure that the deficient	
	(every) 2 hr (hou	ır) PRN (as needed)			practice does not recur: a	
	muscular skeleta	ıl pain."			Licensed Nurses will comple	
					Medication to Medication	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Review of a han	d written MAR			Administration Record	
		ninistration Record),			Comparison each time they	
	`	//			receive new medication for a	a
		1-06/30/2011, indicated:			resident before the medicati	***
	•	g/5 ml: 30 cc (vial) 2.5			loaded into the medication of	art.
	ml q 2* (hour) P	RN muscular skeletal			Nurses will complete	
	pain". (5 mg=2.	5 ml)			"MEDICATION CARD TO M	
	In addition, the I	MAR indicated:			AUDIT" (Attachment B) log e time they intake medications	
	-	ng/5 ml 0.25 ml q 2*			must sign to show that the a	
	•	ar skeletal pain" (5			has been completed and the	• • • • • • • • • • • • • • • • • • •
		ar skeretar parir (5			medications match the	
	mg=.25 ml)				Medication Administration	
					Record. If there is a discrep	ancy,
	Review of "Resi	dent Progress Notes"			they must immediately notify	•
	indicated:				Unit Manager PRIOR to givi	
	"06/24/11 (late e	entry for 1600 [4:00			the medication or stocking it	
	`	ion variance noted. DNS			the med cart. Clarification w	vill be
	* 3/	g Services), MD			sought as needed and medications returned to the	
	`), ED (Executive			pharmacy as needed. b.	
	`	· · · · · · · · · · · · · · · · · · ·			Licensed nurses and QMAs	were
	· · ·	d. Family @ (at) bedside.			inserviced by the Staff	
	`	r) to check O2 (oxygen)			Development Coordinator	
	sat (saturation) & (and) resp (respirations)				regarding proper Medication	n
	q 15 min (minutes) X 2* then q hr X 4*.				Administration techniques.	
	Wait 4* 'til (until) next dose. Call EMS				(Attachment C.) c Medica	
	resp < (less than: per minute) 12 or sat <				Errors will be reviewed by N	
	88%. B/P (blood pressure) 122/54, P				Management as they occur	to
	,	•			determine cause of error, if	
	(pulse) 108, R (respiration) 16, O2 sat on				possible. Clarification or	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155496 07/06/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 333 W MISHAWAKA RD VALLEY VIEW HEALTH CARE CENTER ELKHART, IN46517 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 2 L/MN (2 liters/minute) = 91 %." correction of orders will occur as needed and staff re-education will occur as needed. d PharMerica "06/24/11 1645 (4:45 p.m.) Spoke c has instituted a new process for (with) family regarding N/O (new order) any concentration change of Morphine Liquid Prescriptions to send to ER if family wished. They (Attachment D). This process stated they would like her to stay @ change took effect on July 6, facility. Resident lying in bed c eyes 2011 and was communicated to closed. Resp even et (and) unlabored @ all PharMerica staff on the same this time " day. The process change is as follows: For any change of concentration in Morphine Liquid The documentation indicated Resident Prescriptions: #109 continued to be monitored as A copy of the new written ordered with respirations at a rate of 10 prescription or the physician telephone order must be printed. recorded twice. The family remained at The word "VOID" must be written the bedside throughout the course of the boldly across the face of the new resident's stay. The resident continued to order or prescription and this receive PRN pain medication as ordered. copy must be attached to the newly dispensed medication. The resident expired on 06/26/11 at 1850 PharMerica staff must document (6:50 p.m.). this change of concentration with the nurse's name, date and time. The DNS was interviewed on 07/06/11 at IV. How will the corrective actions be monitored to ensure 8:30 a.m. in regards to the "variance". the deficient practice will not The DNS indicated Resident #109 recur, i.e., what quality received Morphine Sulfate 100 mg/5 ml assurance program will be put dose of 2.5 ml, or 50 mg, rather than the into place: a. Unit Managers transcribed .25 ml, or 5 mg, as ordered. will check MARs daily (Monday through Friday) to ensure that The DNS indicated the pharmacy would "MEDICATION CARD TO MAR normally notify the facility and mark the AUDIT" (Attachment B) is being medication as different concentration as completed as medications are prescribed. The DNS indicated the stocked, and that any discrepancies have been reported medication was administered by a OMA and clarified or corrected prior to (Qualified Medication Aide) after the medication administration or resident was assessed by LPN #3 as the stocking. This will continue for a facility protocol requires. The DNS period of three months, with

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 158496 NAME OF PROVIDER OR SLIPPLIER VALLEY VIEW HEALTH CARE CENTER VALLEY VIEW AND AND AND AND AND AND AND COMPLETION VALLEY VIEW AND AND COMPLETION VALLEY VIEW AND AND COMPLETION VALLEY VIEW CARENDAM OF COMPLETION VALLEY VIEW AND COMPLETION VALLEY VIEW CARENDAM OF COMP	l ·		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
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label(s) and monitoring. V. Completion		1 - 1	pp ******					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155496		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	CON	TE SURVEY MPLETED 6/2011	
	PROVIDER OR SUPPLIER		333 \	T ADDRESS, CITY, STATE, ZIP V MISHAWAKA RD HART, IN46517	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	"Medication Lab 10/31/09", provide time, indicated: "Procedure: 1. A prescription media. Resident's name by Specific direct route of administicts. Medication named. Strength/concedure: 2. Reject improprimedications 4. If the physicial change of the lab "change of order container" Review of a Poli "Pharmacy Servit by the DNS at the "Compliance Guild 3. The pharmacy dispense prescripta authorized prescripta authorized prescripta."	tions for use, including tration. me entration of medications perly, inaccurately labeled an's directions for use pel is inaccurate, place a -check chart" label on the cy and Procedure, titled, ces: 02/23/11", provided time, indicated: idelines: y agrees to accurately potions based on riber orders cy screens each new		Date: 8-2-11		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
		155496	B. WING		07/06/2011
	PROVIDER OR SUPPLIER		333 W	ADDRESS, CITY, STATE, ZIP CODE MISHAWAKA RD ART, IN46517	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
F0502 SS=E	11. Pharmacy re that could result outcome to the consubscriber" 3.1-25(g)(1) 3.1-25(l)(5) The facility must preservices to meet the facility is respetimeliness of the subscriber the facility failed laboratory tests with by physicians for reviewed for diagof 22. (Residents and #76) Findings include 1. The record of reviewed on 06/3 indicated diagnost limited to, diabet and hypertension Physician's Order indicated: "02/10/2011: credurine test) annual	rovide or obtain laboratory ne needs of its residents. onsible for the quality and ervices. reviews and interviews, to ascertain the vere obtained as ordered of 5 of 22 residents gnostic tests in a sample of 8 #85, #104, #36, #67, Resident #85 was 10/11 at 10:00 a.m. and see including, but not es, Parkinson's, anemia, and research for 06/2011, eat/alb ratio (a specific	F0502	F502 Administration (The facility must provide or obtained sof it's residents) I. Vacorrective actions will be accomplished for those residents found to have be affected by the deficient practice: a. Physicians, Residents and/or Family/PO Residents affected were info of labs that were not obtaine physician's order. b. Order clarification was received for resident regarding the order and labs were obtained as ordered. II. How have oth residents having the potent to be affected by the same deficient practice been identified and what correct actions will be taken for the residents: a. Whole house laboratory audit was contract with South Bend Medical Foundation and completed of	the What As of rmed d per each ed lab er tial

li ´					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155496	B. WIN			07/06/20	011
			P. (12)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	MISHAWAKA RD		
VALLEY.	VIEW HEALTH CAF	RE CENTER		1	RT, IN46517		
	_				K1, IN40517		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Interview with th	e North Unit Manager, at			6-28-11. (Attachment E) b.		
	the time, indicate	ed she was unaware the			of all lab orders obtained after		
	test was not done				South Bend Medical Founda Audit was completed by the		
	2. The record of Resident #104 was				Managers on 7-15-11.	Offic	
					(Attachment F) c. Any errors	s or	
					omissions identified by the a		
		29/11 at 9:00 a.m. and			process will be corrected an		
	indicated diagnos	ses including, but not			family, resident or POA and		
	limited to, diabet	es, CAD (coronary artery			physicians made aware.	ı.	
	disease), hyperte	nsion, morbid obesity,			What measures will be put	into	
	and anemia. Rev	view of a Physician's			place or what systemic		
		06/2011, indicated:			changes will be made to		
	· ·	·			ensure that the deficient		
		cro/creat ratio (a specific			practice does not recur: a.		
	urine test) annual	-			Licensed nurses were inserv		
	"07/05/2010: CE	BC w/o diff (with/out			by Staff Development Coord		
	differential: with	out a breakdown of			regarding lab order procedu		
	components) and	CMP monthly X 3 then			and new process of recording	- 1	
	quarterly (4 time	•			routine labs on the MEDICA ADMINISTRATION RECOR		
	* · ·	ot contain the lab results.			(Attachment G) b. All currer		
	The record did in	or contain the lab results.			new routine lab orders will be		
					added to the MEDICATION		
		e North Unit Manager,			ADMINISTRATION RECOR	D and	
	on 06/29/11 at 5:	10 p.m., indicated the			will be signed out by license	d	
	facility discovere	ed the labs were not			nurse as the labs are		
	completed during	g a QA (Quality			completed. c Unit Managers		
	, ,	ans to track and trend			maintain 2 year calendars w		
		ies) in 03/2011 and the			routine labs listed in the mor		
		· ·			they are due. Unit Manager		
	1 ^ *	tified at the time the			maintain and review these o daily basis (Monday through		
		was not done as well as			Friday) to ensure that routing		
	the CMP's for 07	/2010, 08/2010, 09/2010,			are completed as ordered. d		
	and 12/2010.				MEDICATION ADMINSTRAT		
					RECORDS will be reviewed		
	3 The record of	Resident #36 was			monthly by Medical Records	and	
	3. The record of Resident #36 was reviewed on 07/01/11 at 11:00 a.m., and			a Licensed Nurse during end			
		·			the month "change over" to		
	~	ses including but not			ensure that no scheduled ro		
	limited to, demer	ntia, depression,			lab orders are "dropped" fror	n the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155496	A. BUI B. WIN	LDING		07/06/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R					
\	\	DE CENTED		1	MISHAWAKA RD		
VALLEY	VIEW HEALTH CA	RE CENTER		ELKHA	RT, IN46517		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	hypertension and	d hypothyroidism.	İ		MAR. IV. How will the		
	**	vsician's Order Sheet,			corrective actions be		
	dated 05/2011, indicated:				monitored to ensure the		
					deficient practice will not r	ecur,	
		"09/30/2008 TSH (Thyroid Stimulating			i.e., what quality assurance	e	
	Hormone) quarterly."				program will be put into pl		
	The record conta	ained a TSH dated			a. Director of Nursing Serv		
	10/15/10.				will review Unit Managers L		
					Calenders on a weekly basi		
	Interview with t	he North Unit Manager, at			perform a random audit of a		
		ed the Resident #36 had a			one resident per unit per we ensure that scheduled labs		
	1				completed as ordered and r		
	1	refusing ordered lab tests			of the lab are located on the		
	and provided inf	formation the resident			resident's chart. Weekly au		
	refused a blood	draw on 04/15/11. The			will continue for a period of		
	Unit Manager w	ras unaware the record did			months, with monthly audits		
	"	result for a 01/2011			continue thereafter. b Res	ults of	
	TSH.	7 100ait 101 a 01/2011			Audits will be presented to t	he	
	1511.				Performance Improvement		
					Committee monthly for a pe		
	1	ility Policy and Procedure,			of six months for review with	1	
	provided by a co	orporate DNS on 07/05/11			extension of review as needed. Extention of review	, sadill	
	at 8:30 a.m., title	ed, "Renewed or			be based on results of DNS		
	Recapitulated (F	Recap) Physician's Orders,			calender review. If no sche		
	1 -	ords, and Treatment			routine lab orders are "drop		
	Records: 10/31/9				from the MAR or not obtained		
	Records. 10/31/	oo malcated.			ordered, PI review will		
					discontinue. V. Completior	i	
	1	ery 30 days physician's			Date: 8-2-11		
	orders are valida	ated that physician orders					
	are clear, compl	ete, and signed					
	Physician's orde	rs are reviewed and					
	revised"						
	10,1504						
	"Procedure: 2	Validate the physician's					
		acy. 3. Review new					
		•					
	1	with the old current					
	orders"						

STATEMENT OF DEFICIENCIES		155496		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION				A. BUILDING 00			07/06/2011	
155490			B. WIN		A DDDEGG CITY GTATE ZID CODE	0170072	011	
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE			
VALLEY VIEW HEALTH CARE CENTER			333 W MISHAWAKA RD ELKHART, IN46517					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE		
	4 71 1 . 0	Desident IICT						
		Resident #67 was						
		11 at 9:15 a.m., indicated						
		iagnoses included, but						
	were not limited							
	hypertension, and	d urinary retention.						
	A The Physician	n's Order Sheet dated						
	1	an order dated 4/20/11						
	· ·							
	for a Hemoglobin A1C (a laboratory test for diabetes) to be drawn every three							
	months.	e drawn every timee						
	months.							
	The laboratory tests in the resident's chart were reviewed and was unable to locate the April 2011 Hemoglobin A1C laboratory test.							
	Interview on 7/5/	'11 at 10:00 a.m., with						
	the South Unit Manager RN in regard to the April 2011 Hemoglobin A1C (HGB A1C) laboratory test. The South Unit Manager RN indicated the laboratory test for HGB A1C got missed and unsure why the Hemoglobin A1C was not drawn back							
	in April 2011.							
	1 -	Manager RN further						
		nt #67's Physician was						
		1 and an order was						
	received to obtain the HGB A1C laboratory test.							
	The Hemoglobin	A1C laboratory test						
	result that was o	btained was dated 7/1/11						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPL	COMPLETED		
		155496		B. WING			07/06/2011	
		II.	P. 1121		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF PROVIDER OR SUPPLIER					MISHAWAKA RD			
VALLEY VIEW HEALTH CARE CENTER			ELKHART, IN46517					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE	
	at 1740 (5:40 p.r	n.).						
	1	n's Order dated 6/8/11						
	indicated to obta	in annually the laboratory						
	test for"microalb	o/creat" laboratory test						
	(Microalbumin/C	Creatinine Ratio).						
	The Microalbum	in/Creatinine Ratio						
	laboratory test w	as dated as obtained on						
	6/14/11.							
	On 7/1/11 at 10:30 a.m., interview with							
	the South Unit Manager RN in regard to							
	the Microalbumin/Creatinine Ratio							
		ot done until 6/14/11, and						
	1	Manager indicated when						
		ry sample was obtained						
		aboratory the Nurse had						
		•						
	marked the incorrect test to be obtained.							
	The South Unit Manager further indicated the Nurse had marked the laboratory							
	1 ~	an urinary analysis test						
	and not as a Microalbumin/Creatinine							
	Ratio test.							
	5. The record of Resident #76 was							
	reviewed on 6/29/11 at 10:15 a.m., and							
	indicated Resident #76's diagnosis							
	included, but were not limited to, chronic							
	embolism and thrombosis.							
	The Physician's Order dated 5/25/11 indicated to obtain on 5/31/11 a							
	Prothrombin/ International Ratio (a							

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/06/2011		
NAME OF PROVIDER OR SUPPLIER			p. wind	STREET A	DDRESS, CITY, STATE, ZIP CODE			
VALLEY VIEW HEALTH CARE CENTER			ELKHART, IN46517					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ON SHOULD BE COM HE APPROPRIATE		
	laboratory test for blood clotting) (PT/INR).							
	The laboratory tests in Resident #76's chart were reviewed and was unable to find a PT/INR laboratory test result for 5/31/11.							
	On 6/29/11 at 2:00 p.m., the South Unit Manager was interviewed in regard to the 5/31/11 PT/INR laboratory test and indicated the resident's Physician was notified on 6/2/11 that the PT/INR was not drawn on 5/31/11, and a new Physician's Order was received to obtain the laboratory test on 6/6/11.							
	Manager was int PT/INR laborato 5/31/11 and indi- laboratory test w Treatment Admi	0 a.m., the South Unit derviewed in regard to the dry test not done on cated the PT/INR ras not placed on the mistration Record for result the laboratory test						
	on 6/6/11 indicate (PT) was elevated 9.0 to 12.0. The PT/INR laber 6/6/11 indicated	oratory test result drawn ted the Prothrombin Time ed at 12.4, normal range is oratory test result dated the current order for dication to prevent blood						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 5/2011
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW HEALTH CARE CENTER			333 W	ADDRESS, CITY, STATE, ZIP C MISHAWAKA RD .RT, IN46517	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	milligrams times coumadin 7.5 mi was changed to o	Istrate Coumadin 10 I day and alternate with lligrams times 3 days coumadin 7.5 milligrams alternate with coumadin day.				